ZIKA TEST REQUEST FORM

COUNTY OF LOS ANGELES
Public Health

Public Health Laboratories
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CA Certified PHL #335637
CLIA #05D1066369

FAILURE TO COMPLETE ALL FIELDS WILL RESULT IN SPECIMEN REJECTION OR DELAYED TESTING

SUBMIT A SEPARATE TEST REQUEST FOR EACH SPECIMEN TYPE

For Zika virus testing eligibility:
www.publichealth.lacounty.gov/acd/Diseases/EpiForms/ZikaEligibility.pdf
For Zika virus testing and notification information:
www.publichealth.lacounty.gov/acd/ZikaTesting.htm

PUBLIC HEALTH LAB USE ONLY

SUBMITTER INFORMATION

Date Submitted				
Requesting Physician Name (Last, First)	Requesting Physician Phone	Requesting Physician Email		
Facility Name	Facility Address (Street)	City	State	Zip
Facility Phone Number	Secure Fax Number For Results Reporting	Contact Person For Specimen and Phone Number		

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)	Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	
Patient Address (Street)	City	State	Zip
Patient Primary Telephone Number	Patient Alternate Phone Number	MRN/Patient ID	

LAB INFORMATION

Specimen Source
☐ Serum ☐ Cord Blood ☐ Amniotic Fluid
☐ Urine ☐ Placenta ☐ Other:_____

Specimen Collection Date/Time (hh:mm AM/PM)
____/____/____ _____:_____ **AM/PM**

Specimen Storage Condition
☐ Refrigerated
☐ Frozen (-20°C)

TEST(S) REQUESTED – Current Lab Testing Algorithms Available at http://www.cdc.gov/zika/laboratories/lab-guidance.html

☐ Arbovirus serology panel (with reflex to confirmatory PRNT or rRT-PCR if required) for Zika, Chikungunya, Dengue, and West Nile Viruses
☐ Arbovirus rRT-PCR (with reflex to serology or PRNT if required) for Zika, Chikungunya, and Dengue Viruses
☐ Immunohistochemistry (fixed tissue or paraffin block)
☐ Histopathology (fixed tissue or paraffin block)
☐ PRNT for Zika/Chikungunya/Dengue/West Nile Virus Confirmation (Previous IgM serology positive result(s) required for PRNT)

CLINICAL INFORMATION

PREGNANCY STATUS

☐ Yes: # Weeks Pregnant _____ OR Estimated Due Date: _____ ☐ Ultrasound Evidence of Microcephaly/Calcification
☐ Not Pregnant ☐ Not Applicable

SYMPTOMS (CHECK ALL APPLICABLE)

☐ Symptomatic: ☐ Fever ☐ Arthralgia ☐ Rash ☐ Conjunctivitis AND Symptom Onset Date: _____
☐ Asymptomatic
☐ Guillain-Barré Syndrome: Onset Date: _____
☐ Other, Specify:

FLAVIVIRUS HISTORY (CHECK ALL PREVIOUS KNOWN VACCINATIONS AND ILLNESS) ☐ Flavivirus History Unknown

☐ Tick-borne Encephalitis ☐ Yellow Fever ☐ Japanese Equine Encephalitis ☐ West Nile Virus ☐ Saint Louis Encephalitis ☐ Dengue

TRAVEL AND EXPOSURE HISTORY

See current areas with Zika transmission at http://www.cdc.gov/zika/geo/active-countries.html

Did patient travel to an area with Zika transmission (including U.S with ongoing local Zika spread) within 14 days of symptom onset? ☐ Yes ☐ No ☐ Unknown
List all cities/countries/areas of travel: _____ Last Date of Travel: _____

Did patient's sexual partner travel to area with Zika transmission (including U.S. with ongoing local Zika spread)? ☐ Yes ☐ No ☐ Unknown
List all cities/countries/areas of travel: _____ Last Date of Travel: _____
Last Date of Unprotected Sexual Intercourse: _____ OR ☐ Unknown

Is the patient an infant with any of the following? ☐ Yes ☐ No
1) ☐ A mother with laboratory evidence of Zika virus infection Specify Mother's Name & Date of Birth:_____
2) ☐ Evidence of microcephaly/other birth defect: _____ **AND** ☐ A mom with recent travel to an area with Zika or had unprotected sex with traveler